TESTIMONY

Presented to the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
HEALTH SUBCOMMITTEE

Hearing on Use of Medical Imaging Services:
Providing Appropriate Care for Medicare Beneficiaries

Tuesday, July 18, 2006

Presented by
Pamela S. Douglas, MD, MACC

On behalf of the
Coalition for Patient-Centered Imaging

For more information, contact the American College of Cardiology at (800) 435-9203

Chairman Deal and Members of the Subcommittee, I am pleased to testify before you today on behalf of the American College of Cardiology (ACC) and the Coalition for Patient-Centered Imaging (CPCI), an alliance of more than 20 physician specialty groups and health care organizations united in the strong belief that office-based medical imaging is an integral component in the delivery of quality patient care. I am a board-certified cardiologist and the Division Chief and Ursula Geller Professor of Research in Cardiovascular Diseases at Duke University Medical Center. I also serve as Director of Cardiovascular Research Strategy at Duke Clinical Research Institute. I am the immediate past president of the ACC and a past president of the American Society of Echocardiography (ASE).

I welcome the opportunity to offer the Coalition's perspective on the importance of office-based imaging and commend the Subcommittee for holding this hearing. Medical technology has evolved to provide crucial support to skilled patient care. Advanced technologies unheard of a decade ago are now key tools in the prompt and efficient diagnosis and treatment of patients.

We believe that patients, physicians, policymakers and payers are at a crossroads in the political debate over the provision of imaging services. The title of today's hearing aptly reflects what I believe is the core of this debate: Ensuring that medical imaging received by Medicare patients is in fact clinically appropriate. I expect that this Subcommittee will hear from others today about why reductions in payments for office-based imaging services contained in the Deficit Reduction Act (DRA) are bad policy and could negatively affect patient care. We agree with this assessment and appreciate the commitment many of you on this Subcommittee have already

made to reexamine the DRA imaging policy in a more thoughtful manner, especially given the closed-door, eleventh-hour nature of this significant policy decision.

However, in keeping with the theme of today's hearing, I want to focus on the quality assurance tools that my specialty of cardiology and other physician specialties currently use -- or are developing -- to guide physicians in the appropriate ordering and performance of imaging tests. We firmly believe that until there are benchmarks for measuring appropriateness that will allow for a better understanding of imaging utilization growth, draconian approaches such as the one taken under the DRA will not only persist, but eventually negatively affect patient care and have no affect on utilization.

My testimony today will also highlight that imaging services, when provided by experienced and qualified physician specialists with training and experience, are important tools that vastly improve patient care. I also hope to provide a better context in which to view imaging growth.

Office-Based Medical Imaging Constitutes Good Patient Care

Advancements in medical imaging have changed the way cardiologists, urologists, orthopaedic surgeons, breast surgeons, obstetricians, neurologists, endocrinologists and other specialty physicians deliver patient care on a daily basis. Specialty physicians are uniquely qualified to provide imaging services specific to their specialty because they are trained in both diagnostic imaging techniques, and in the structure and function of the organs and systems they are imaging. By integrating medical technology into care plans, it offers the opportunity for earlier, better and more accurate diagnosis of disease or injury and the prospect of better quality care.

Today in cardiology, we are fortunate to have a wide range of non-invasive imaging techniques to combat and treat disease. With the selective use of echocardiography, nuclear imaging, CT and MR we can evaluate the heart to answer specific clinical questions presented by patients. This allows physicians like me to define the functional adequacy of the heart to pump blood in heart failure patients, or for my colleagues to assess the significance of plaque within a vessel wall by viewing it in three dimensions. We can now visualize what in the past required subjecting a patient to an invasive procedure. The ability to view various aspects of the heart is important to providing cost effective and minimally invasive diagnosis and risk assessment.

In addition to employing medical imaging for diagnostic purposes, physicians now use imaging to guide minimally invasive treatments and to track ongoing treatment protocols.

Two examples are ultrasound-guided needle breast biopsies and image-guided biopsies of prostate lesions. In breast surgery, ultrasound-guided breast biopsies in the physician office can be performed at a third of the cost and in about half of the time of an open surgical biopsy. Ultrasound-guided breast biopsy allows for less-invasive evaluation of mammographic lesions, with more reliable tissue differentiation, more streamlined patient care and characterization, and improved staging of disease. Patient satisfaction is also increased with shorter recovery times and minimized scarring. In addition to the clinical and patient satisfaction benefits, The Lewin Group estimates that use of image-guided core breast biopsies instead of open biopsies saved the Medicare program $88 million between 2001 and 2003.[i]

Urology offers another example where advancements in medical imaging have led to less-invasive and less-painful procedures. Older men often experience difficulty urinating because of prostate enlargement. To evaluate this problem, physicians must learn how much urine is retained in the bladder after voiding, known as "residual urine." For many years this was determined by passing a catheter through the urethra and into the bladder, the amount of urine drained from the bladder was then measured. Introducing a catheter into the bladder, in addition to being uncomfortable, also may introduce infection. Today, many urologists employ a small ultrasound machine designed specifically for this task. This test can be done in the urologist's office and eliminates the use of a catheter and the danger of infection.

The expectation of society, and of our patients, is that we will employ these marvels of medicine to achieve best practice outcomes for every care interlude. That means the integration of medical imaging as part of the treatment plan is here to stay.

Growth in Medical Imaging Utilization

There is no dispute that growth in medical imaging utilization is occurring. What is in dispute is how much of the growth is out of line with other Medicare Part B spending and whether increased utilization in imaging is creating cost savings elsewhere in the Medicare program. Last year the ACC commissioned a study by The Lewin Group to examine the growth in diagnostic imaging services.[ii] Based on those study findings, we were and remain concerned that the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) continue to cite growth rates for imaging services without taking into account the shift in site of services out of hospitals and into physician offices. MedPAC, in its

March 2005 report to Congress, acknowledged about 20 percent of the growth in imaging services paid under the physician fee schedule between 1999 and 2002 was due to this shift in site of services, but did not account for this shift in its growth comparisons.[iii] Furthermore, MedPAC did not include all Medicare Part B services in its comparison of growth rates for imaging and other services. In particular, MedPAC omited durable medical equipment, chemotherapy drugs and other drugs covered under Part B, and ambulance services. Therefore, comparison in growth of imaging and the growth of other Medicare Part B services is distorted significantly. According to the The Lewin Group analysis, when all Part B services are included and the changes in the site of service are accounted for, imaging grew at an average annual rate of 11.2 percent from 1999-2004 compared with an average annual rate of 6.9 percent for all Part B services.[iv] The increase in imaging utilization has resulted in particular scrutiny of advanced imaging such as CT and MRI. The Lewin Study found that these technologies had a higher rate of growth from 2003-2004, approximately 18 percent and 20 percent respectively, than other imaging technologies. The study also showed that radiology performed 84 percent of CT scans and 65 percent of MRIs.[v]

There are a number of reasons for the growth in imaging that are not adequately examined by MedPAC or CMS. The Coalition hopes that before further policy changes are considered, a more thorough analysis will occur as to the reasons behind the growth, including shift in site of service, clinical substitution, clinical appropriateness through the adherence to evidence-based scientific guidelines, advancements in technology, and demographic changes.

When growth is distorted, or factors for growth are not fully factored into an analysis, it leads to inadequate and/or inappropriate policy responses.

Responding to Medical Imaging Utilization Growth

As I mentioned in my introduction, patients, physicians, private payers and the federal government are all caught in the middle of political debate over the growth and future of medical imaging. The DRA cuts enacted this year are just one example of several onerous responses to imaging utilization growth. Proposals set forth by MedPAC include setting federal standards for accreditation of facilities and certification of individuals. I will tell you today that these measures are not, and should not, be viewed as cost-containment mechanisms. They are tools to improve quality – a point I will elaborate on later in my testimony.

Cuts in Medicare Reimbursement for Medical Imaging Services

Earlier this year, as part of the DRA, Congress enacted a provision that cuts payments for many office-based imaging services. The law requires that Medicare payment for the equipment, supplies, non-physician personnel, and overhead associated with non-hospital imaging services *(the technical component)* be paid, effective Jan. 1, 2007, at either the Hospital Outpatient Prospective Payment System (HOPPS) rate or the Medicare physician fee schedule amount, whichever is lower. This provision was included in neither the House nor the Senate deficit reduction bills, but emerged from conference committee and was enacted without ever having been subject to public comment or scrutiny.

Not surprisingly, the DRA will result in draconian payment reductions for some imaging services in non-hospital settings. For many of those services, anticipated reductions as a result of the DRA are in the range of 35-55 percent. For example, Medicare payment for ultrasound guidance procedures performed as part of minimally invasive biopsies for the diagnosis of breast cancer would be reduced by 35 percent; Medicare payment for positron emission tomography (PET)/CT exams used to diagnose cancerous tumors and to determine the effectiveness of cancer treatment would be reduced upward of 50 percent; and payment for bone densitometry studies to diagnose osteoporosis (a recently added Medicare screening benefit) would be reduced by more than 40 percent.

The Coalition is troubled by the precedent-setting nature of this provision. Nowhere else in Medicare are physician payments tied to hospital outpatient reimbursement. The methodologies used to determine payment rates for hospital and non-hospital imaging services are based on different data and different methodologies. Therefore, if the methodologies and data differ, why would Congress require that a methodology used to determine reimbursement in one setting be used to set reimbursement in a different setting for the same service? If Congress' intent was to "level the playing field" for imaging reimbursement, payments for office-based imaging services that are lower than the hospital outpatient rates should be increased. What is clear is that the policy was built less on strong or sensible policy rationale and more on the need to create savings to offset other spending. While the physician community appreciates Congress' intervention to stop a negative update in Medicare physician payments this year, the zero-sum politics of physician payment is unsustainable.

The DRA medical imaging cuts cannot be considered in isolation. There are other policy changes that will or could negatively affect medical imaging reimbursement in 2007. As part of the DRA, Congress imposed a multiple procedure discount to selected diagnostic imaging procedures. Eligible procedures were identified and grouped into 11 "families" of related CPT imaging codes. For these procedures, Medicare will make full payment for the procedure with the highest payment rate and then apply a 50 percent reduction in the payments for second and subsequent imaging procedures in the same family that are performed during the same session.

Most recently, CMS published a proposal to completely revamp the methodology used to determine the physician fee schedule technical component and other physician practice expenses. This proposal will affect imaging technical component services, but impact varies by services.

While such payment reductions may result in short-term savings, there is no evidence that decreasing payment rates will reduce any inappropriate utilization. However, Medicare cuts such as those highlighted above, not to mention the pending 4.6 percent across-the-board cut, are likely to result in reduced Medicare patient access, higher beneficiary co-payments, and lower quality due to the reduced availability of funds for imaging equipment maintenance, replacement, and upgrades.

According to an online survey conducted May 24-June 21, 2006 by CPCI of more than 3,900 individual physicians, practice administrators, and health care professionals across the country, 40 percent of those who had planned to purchase or lease new imaging equipment in 2006 or 2007 delayed or canceled those plans largely due to the DRA cuts.[vi] While this may sound like

good news to payers, it provides no relief to Medicare patients who already endure long waits for imaging services. According to a study recently conducted by the Society for Vascular Ultrasound, on average, patients already wait 10 days to two weeks for non-urgent imaging services in the hospital outpatient department. If Medicare reimbursement for medical imaging services decreases in 2007, 47 percent of respondents said they will cut practice overhead by reducing personnel levels, compensation or fringe benefits; 46 percent say they will discontinue value-added but non-reimbursed patient services; 44 percent will freeze or delay hiring of clinical staff; 40 percent will delay the purchase or updating of electronic medical record software; and 39 percent will no long provide imaging services to Medicare beneficiaries.

When asked where patients would go to receive imaging services if they were no longer provided in their office, the respondents replied that 83 percent would be sent to hospitals for those services. According to the American Hospital Association, the demand for hospital care, both outpatient and inpatient, is rising and half of emergency departments are "at" or "over" capacity.[vii] If medical imaging becomes a fiscally unsustainable service for physician practices or if restrictive standards or regulations are imposed, patients will be forced into already over-crowded hospitals to receive imaging services. Medicare patients who must go to the hospital outpatient department to receive imaging services may not only endure significantly longer wait times, delayed diagnosis and treatment, but their co-payments will also jump from 20 percent in the physician office setting to up to 40 percent of charges in the hospital outpatient department setting.

Federal Standards for Office-Based Imaging

Some policymakers have called for the imposition of federal "standards" as a mechanism to increase quality and safety in the provision of imaging services. It is likely that under such a regulatory scheme, nationally-based imaging norms would be developed, implemented and administered by CMS and would apply to both the technical (e.g., equipment/overhead) and professional components (e.g., interpretation of the imaging) of imaging services.

We do not oppose the use of criteria that foster and support better quality and safety of diagnostic imaging, but we caution against the federal government's having a role in this realm. The federal government has not played a part in the credentialing and determination of privileges of physicians to provide medical services. Typically, the practice of medicine has been left to the states to govern. States most commonly rely on the expertise of medical professional organizations or boards to create standards, guidelines, or other criteria for their members. The development and imposition of federal standards on the practice of medicine would represent an enormous new role for Congress and CMS that could lead to the politicizing of medical privileging – physician organizations would incessantly "lobby" the federal government on medical scope of practice and other, similar matters, most appropriately left for the states to decide.

To be candid, inherent in this discussion are "turf" issues as well as concerns about increased utilization and appropriateness of testing. Some, notably in the radiology community, have mounted criticisms based on quality of diagnostic services performed by non-radiologists. They seek to set standards that would effectively allow only radiologists to perform and interpret

images and bill Medicare for their services, particularly in certain "advanced" modalities, such as CT, MR and PET. Yet, there is no credible evidence to demonstrate systematic quality problems in performance and interpretation of diagnostic medical imaging by specialists who are not also board-certified radiologists.

Federal quality/certification regulations or thinly veiled attempts to protect "turf" will not lower utilization, but will merely redirect it. Nor do such regulations address the challenge of ensuring that the right test is provided by qualified personnel in the right setting, at the right time. Ensuring the quality and safety of medical imaging can only be accomplished through costly and painstaking work by the professional medical organizations who are meeting the challenge by developing training programs and requirements, appropriateness criteria, guidelines, and other quality-improvement tools such as performance measurements. Medical organizations are at different stages in their development of these types of tools. Nevertheless, it is appropriate that these efforts be specialty and modality specific and have significant input from the respective specialty organization(s).

Ensuring Appropriate Use of Medical Imaging Tests

The ACC, the American College of Surgeons (ACS), the American Academy of Orthopaedic Surgeons, the American Association of Clinical Endocrinologists, and other specialties are making strides in developing and using tools including accreditation and training programs, guidelines, and performance measures, that will facilitate the delivery of quality and appropriate imaging services. For instance, large multi-specialty medical groups utilize practice guidelines – whether related to chronic diseases like diabetes or imaging services. Requiring these large

providers to adopt a national, one-size-fits-all standard that overrides carefully considered care management processes within the group setting makes little policy sense.

American College of Cardiology

Cardiology is a leader within the imaging community in the development of quality-improvement tools, largely because of the dependence upon imaging in the provision of cardiac care. Among the ACC's quality efforts is creation of groundbreaking appropriateness criteria for diagnostic tests. The purpose of appropriateness criteria is to address overuse, under use, and misuse of imaging tests. These directives are patient-centric and define "when to do" and "how often to do" a given procedure in the context of scientific evidence, the health care environment, the patient's profile and the physician's judgment.

In October 2005, the ACC and the American Society of Nuclear Cardiology (ASNC) published its inaugural set of appropriateness criteria for Single Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI), commonly known as cardiovascular nuclear imaging. To build the criteria, a representative panel of clinical experts met to assess the benefits and risks of the procedure for different indications, or patient scenarios. The panel used the RAND/UCLA appropriateness method to score each indication, assigning scores within a range of one to nine. Using these scores, the panel identified for each indication whether SPECT-MPI was appropriate, inappropriate or possibly appropriate requiring more patient-specific information. This process and methodology is being used by the ACC to develop appropriateness criteria for cardiac MR and CT and echocardiography, scheduled for release this summer and early 2007, respectively.

Not only do appropriateness criteria promote safe and cost-effective cardiovascular care, these criteria also can help ensure the delivery of more equitable health care among all demographic profiles, minimizing documented disparities. Several third-party payers have adopted the SPECT-MPI appropriateness criteria for diagnostic imaging and the ACC has achieved some success in getting radiology benefit management organizations to update their guidelines to include the SPECT-MPI appropriateness criteria. The ACC is closely monitoring how the appropriateness criteria are utilized to ensure that they are not misused.

To facilitate the adoption of its appropriateness criteria, the ACC is working with the Oklahoma Foundation for Medical Quality, the OK Quality Improvement Organization (QIO), to develop a project proposal based on a recently issued CMS QIO RFP titled "Developing a Framework for Improving Outcomes via Curtailing Harmful Over-Utilization for Chronically Ill Beneficiaries." The proposed project would focus on appropriate utilization of SPECT MPI for cardiovascular patients using the ACC/ASNC SPECT MPI appropriateness criteria. Among the objectives are establishing regional variations in annual volume and growth rates for SPECT MPI, as well as the potential impact of a prospective ordering sheet to foster quality improvement and benchmarking based on the appropriateness criteria.

Already physicians are using the SPECT MPI criteria, allowing them to compare their practice patterns with those of their peers. Ultimately, appropriateness criteria will weed out inappropriate utilization, improve imaging quality and facilitate reimbursement in a performance measurement-based system.

Quality in cardiovascular imaging will require us to adopt new processes for quality improvement. A thorough and thoughtful process must be put in place for measuring quality that begins before the patient even walks through the door. Early this year, the ACC, in partnership with the Duke University Medical Center, convened a two-day Think Tank on Quality in Cardiovascular Imaging with 80 stakeholders representing imaging professional societies, academics, quality experts, CMS, FDA, private payers, equipment manufacturers and pharmaceutical companies. The think tank mapped out a multi-year quality agenda to develop and implement standards as part of an action plan for each imaging modality. These plans include development of patient selection criteria, as well as protocols for measuring the quality of laboratories, image acquisition, image interpretation, communication of results, and improved patient outcomes. The summit proceedings represent a consensus of the leadership of the ACC, American College of Radiology and a host of cardiovascular specialty organizations and will be published in the *Journal of the American College of Cardiology* later this year.

American College of Surgeons

To ensure that surgeons who use ultrasound are qualified and that the ultrasound facilities and equipment they use are appropriate for the medical application and meet and maintain quality standards, a thorough verification program was developed by the ACS for surgeons and surgical residents. The program provides a formal means of education verification to assist in credentialing. Through didactic instruction, practical demonstration, and hands-on sessions, the ACS "Voluntary Verification Program for Surgeons in the Use of Ultrasound" provides advanced knowledge of clinical applications tailored to specific types of surgical clinical

practice, including acute/trauma, vascular, breast, abdominal, intraoperative/laproscopic, and head/neck.

The ACS has also developed the "Stereotactic Breast Biopsy Accreditation Program" to ensure that only qualified personnel perform stereotactic breast biopsies for the diagnosis and treatment of breast cancer and appropriate equipment is used to ensure that women receive optimum tissue sampling with the lowest possible risk. The program offers physicians the opportunity for peer review and comprehensive evaluation of their facility's staff qualifications, equipment, quality control and quality assurance programs, image quality, and breast dose. Those facilities successfully meeting all of the criteria are given a three-year accreditation and the American Cancer Society, the National Alliance of Breast Cancer Organizations, National Cancer Institute, Y-ME and other patient referral organizations are provided with an updated list of accredited facilities.

The American Academy of Orthopaedic Surgeons

The American Academy of Orthopaedic Surgeons (AAOS) has established quality guidelines to enhance orthopaedic surgeons' diagnosis and treatment of various musculoskeletal conditions. Workgroups consisting of members of AAOS and Orthopaedic Specialty Societies, with scientific and clinical expertise, were organized to create the guidelines. Workgroup members attended workshops to learn how to develop, evaluate, and revise evidence-based guidelines. They created "decision trees" or algorithms for treating knee and shoulder pain, common orthopaedic conditions. In each algorithm, suggestions for the most effective and efficient imaging options, based on the patient problem, standards of care, and the advantages and

disadvantages for using each imaging modality help orthopaedic surgeons make an accurate diagnosis and treatment plan. Additional guidelines are under development to ensure appropriate patient care, including the appropriate use of imaging technology, for all orthopaedic conditions.

In addition, more than half of all orthopeadic surgeons have a formal rotation in radiology during training. Orthopaedic surgeons cannot become board certified physicians without passing an exam of which half of all questions on part one and all of the questions on part two require the interpretation of an image.

American Association of Clinical Endocrinologists

The American Association of Clinical Endocrinologists (AACE) and the American College of Endocrinology (ACE) have long recognized the need for specialized education and training to verify knowledge, skills, and capabilities in endocrine imaging services.

Since 1998, the AACE and ACE have sponsored the Thyroid Ultrasound and FNA Biopsy Accreditation Course®. Physicians who successfully complete this course have the indications and limitations of thyroid ultrasound and how it integrates with other thyroid tests to improve the diagnosis and management of thyroid disease. Physicians successfully completing this course and examination receive a certificate of accreditation for Thyroid Ultrasound & Ultrasound Guided FNA Biopsy. Ultrasound is an example where a highly skilled endocrinologist or other qualified physician can utilize real time ultrasonography to optimize and facilitate excellence in patient care, procedures and outcomes.

AACE and ACE also sponsor Endocrine University®. Endocrine University® provides specially designed curriculum and programming to help prepare endocrine fellows for entering clinical practice. Endocrine University® is held once a year and is open only to final year fellows-in-training in endocrinology. The course is held at the Mayo Clinic in Rochester, Minn., and provides fellows with an intensive six-day curriculum which covers thyroid ultrasound accreditation, bone densitometry accreditation, Metabolic Laboratory CLIA certification, practice management topics, and insulin management.

It is important that the federal government recognize and not duplicate or override specialty society efforts to ensure quality and safety by imposing non-specialty specific requirements. There are already a number of specialty-specific programs designed to improve imaging quality, as well as state laws and regulations in place that stipulate equipment quality controls and technologist training requirements. Specialty society efforts should be encouraged and quality related initiatives for diagnostic imaging should be considered by Congress in the context of broader pay-for-performance concepts.

June 2006 Medicare Payment Advisory Commission Recommendations

As Congress considers policy proposals that relate to medical imaging, we hope that you will consider what further cuts in medical imaging services will do to quality-improvement efforts. The passage of the DRA imaging cuts sent a message to the physician community that Congress cares more about ratcheting down costs than improving quality. Continued cuts of this nature will have an absolute stifling effect on quality improvement efforts by the physician specialty community.

The Coalition is concerned with a recommendation in MedPAC's June 2006 Report to Congress that CMS adjust the equipment utilization assumption used in physician practice expense payment calculations upward from 50 percent. Such an adjustment could severely affect payments for office-based imaging services at a time when imaging is already poised for reimbursement cuts. MedPAC's recommendation, that would be applicable to all imaging services, was based predominately on a study of MRI and CT utilization. We hope that the Committee understands that the ultrasound equipment use rate is likely to be different from the utilization rate of an MRI machine because of the practice patterns of the specialties that use each type of imaging modality. For example, ultrasound services are one element of the clinical care provided by many specialties and, as such, are used as an adjunct to the practice of many physicians whose primary occupation is direct patient care – i.e. surgical procedures and office visits. MRI and CT, on the other hand, are more often used in a radiology practice setting as the only type of care provided, and thus are less likely to be idle during business hours.

We request caution on the part of Congress and CMS and ask that MedPAC be directed to expand its survey to collect data using a large, broad-based sample which includes different equipment types across all sites of service, distinguishing by specialty before changes in equipment utilization rates can be considered for equipment in non-hospital sites of service. Because of the limitations of the MedPAC study, it would only be prudent at the present time for MedPAC or CMS to propose adjustments in utilization assumptions for free-standing imaging facilities that have billed Medicare for CT and MRI services.

Also in MedPAC's June 2006 report, it concluded that the assumption of 11 percent in calculating the cost of capital for medical equipment purchases is too high. MedPAC arrived at this conclusion based upon a review of Federal Reserve Board information on commercial loans, but with the admission that a more specific source of data on the subject had not been located. The Coalition disagrees with this conclusion and believes that if MedPAC staff were to survey financing companies that lend money for medical equipment purchases, their conclusion may be different.

The Coalition was able to obtain information from Key Equipment Financing regarding the current and expected future cost of capital. KeyCorp, the parent company for Key Equipment Financing, is one of the nation's largest bank-based financial services company. For more than 20 years, Key Equipment Finance has been providing financing to health care providers including medical doctors, clinics, group practices and hospitals. The information from Key Equipment Financing indicates that rates for long-term leases/purchases for imaging equipment have ranged from 8-10 percent over the last few years, but that these rates are abnormal and have been the result of historically low prime rates. However, with the recent actions by the Federal Reserve to raise the base interest rates that banks pay to borrow money, the interest being charged today on new long-term leases is expected to be between 9-11 percent, depending on the amount of money borrowed.

We believe that this information validates that CMS' estimate for the cost of capital continues to be a correct assumption and is not in need of adjustment. Therefore, we recommend the Subcommittee direct MedPAC to investigate the issue more fully, directly surveying medical

equipment financing companies before they or CMS move forward with recommending any changes to this aspect of the formula for calculating practice expense payments for equipment under the Medicare physician's fee schedule.

Conclusion

The organizations that comprise the Coalition for Patient-Centered Imaging are committed to working with Congress to responsibly address the growth in medical imaging. It is important that we all work together to ensure that Medicare beneficiaries are not denied access to appropriate imaging services provided by qualified physician specialists. Thank you for the opportunity to present our views. I look forward to answering any questions you may have.

---

[i] "An Analysis of the Utilization of Ultrasound Imaging Services in the Medicare Program." The Lewin Group. May 2005.

[ii] "Issues in the Growth of Diagnostic Imaging Services: A Case Study of Cardiac Imaging," The Lewin Group, May 3, 2005.

[iii] Report to Congress: Medicare Payment Policy, MedPAC, March 2005.

[iv] "Issues in the Growth of Diagnostic Imaging Services: A Case Study of Cardiac Imaging," The Lewin Group, Report Addendum, June 20, 2005.

[v] "Issues in the Growth of Diagnostic Imaging Services: A Case Study of Cardiac Imaging," The Lewin Group, May 3, 2005.

[vi] Coalition for Patient-Centered Imaging. Online survey of physicians, practice administrators, and health professionals conducted May 21-June 24.

[vii] "The State of America's Hospitals – Taking the Pulse." American Hospital Association. 2006 AHA Survey of Hospital Leaders.